# EASTCHESTER UNION FREE SCHOOL DISTRICT
## 580 White Plains Road
## Eastchester, N.Y. 10709

***Candida Ambroseo, School Nurse***
***Eileen Egan, School Nurse***
***Lisa Massi, School Nurse***
***HEALTH OFFICE***
***Middle and High Schools***
***(914)793-6130 X4246, X4218,X4243***
***(914)793-0098 FAX***

May 1, 2017

Dear Sixth Grade Parent/Guardian:

Please be advised that in September 2017, all public and private school students **entering seventh grade** in New York State must be **vaccinated** against **meningococcal** disease in order to attend school. In addition, they are **required by law** to submit evidence of having had a **current physical exam, including immunizations**, done within the past year (dated October 2016 and thereafter). We are requesting **a dental certificate** as well.

**All physical exams and immunization records are due October 1, 2017**. You may send them to us at the above address any time before this date.

Sincerely,

| | | |
|---|---|---|
| *Candida Ambroseo* | *Eileen Egan* | *Lisa Massi* |
| Candida Ambroseo, R.N | Eileen Egan, R.N. | Lisa Massi, R.N. |

CA:soc
Encs. Health Cert. Appraisal Form 9_21_11
Dental Health Cert. Form 3_16_09

# EASTCHESTER UNION FREE SCHOOL DISTRICT

***(914) 793-6130***

*NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).*

## HEALTH CERTIFICATE / APPRAISAL FORM

**Name:** _____ **Date of Birth:** _____

**School:** _____ **Gender:** ❑ **M** ❑ **F** **Grade:** _____

### IMMUNIZATIONS / HEALTH HISTORY

❒ **Immunization record attached** **PPD**: ❒ Positive ❒Negative ❒ Not at Risk MD Signature_____ Date: _____

❒ No immunizations given today Chest X-Ray ❒ Positive ❒Negative ❒ Not done Date: _____

❒ Immunizations given since last Health Appraisal: Elevated Lead: ❒ Yes ❒ No ❒ Not done Date: _____

Dental Referral ❒ Yes ❒ No ❒ Not done Date: _____

**Significant Medical/Surgical History**: ❒ See attached _____

**Specify current medical conditions:** ❒ Asthma Diabetes: ❒ Type 1 ❒ Type 2 ❒ Hypertension
❒ Other: _____

**Allergies**: ❒ **LIFE THREATENING** ❒ Food: _____ ❒ Insect: _____ ❒ Other: _____

❒ Seasonal ❒ Medication: _____

### PHYSICAL EXAM

Date of Exam: _____ Height: _____ Weight: _____ Blood Pressure: _____

| | | | | *Referral* |
|---|---|---|---|---|
| Body Mass Index: _____ _____ . _____ | Vision - without glasses/contact lenses | R | L | |
| Weight Status Category (BMI Percentile): | Vision - with glasses/contact lenses | R | L | |
| ❑ less than 5th ❑ 5th through 49th ❑ 50th through 84th | Hearing ❑ Pass 20 db sc both ears or: | R | L | |
| ❑ 85th through 94th ❑ 95th through 98th ❑ 99th and higher | | | | |

❒ **EXAM ENTIRELY NORMAL**

❒ **TANNER**: I. II. III. IV. V.

❒ **SCOLIOSIS**: ❒ Negative ❒ Positive: _____

### MEDICATIONS

Medications (list all) including Over the Counter meds (OTC's) ex. Tylenol, Ibuprofen ❒ None ❒ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

I assess this student to be self-directed ❒ Yes ❒ No Student may self carry and self administer medication ❒ Yes ❒ No

**NOTE: Parent MUST sign below in order for prescribed meds to be given and for student to self-administer. Nurse will also assess self-direction for the school setting.**

**Parent is responsible for providing all medication, including OTC's, in its original container and properly labeled with student's name.**

### PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

❒ **Physically qualified for all activities. No limitations (OR only as checked):**

___ Limited activity: Specify Activity allowed. _____

___ No Activity. Reason_____

❒ **Specify medical accommodations needed for school**: _____ ❒ None

❒ **Known or suspected disability:** _____ ❒ Please monitor

❒ **Restrictions:** _____ ❒ Please monitor

❒ **Protective equipment required:** ❒ Specify: _____

Physician's Name/Address: _____ Phone:_____ License No._____

Physician's Signature: _____ Fax: _____

**Parent Signature: (includes medication consent)** _____Date: _____

*This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director.* *Rev. 9/21/11*

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*Eastchester, NY 10709*
*(914) 793-6130*

## Dental Health Certificate

**Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, K, 2, 4, 7, & 10. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up, ask your dentist to fill out Section 2. Return the completed form to the school nurse as soon as possible. The date of the exam needs to be within 12 months of the start of the school year in which it is requested.**

### Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

### Section 2. To be completed by the Dentist

**The Dental Health condition of _____ on _____ .**

***(name of student)*** **(date of exam)**

***The date of the exam needs to be within 12 months of the start of the school year in which it is requested.*** **Check one:**

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

**Dentist's name and address (please print or stamp )** **Dentist's Signature**